February 25, 2004

Dr. Jimmy Clarke, Coordinator
Louisiana Healthcare Summit
c/o Ms. Catherine Kitchen
Office of the Governor
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Dear Dr. Clarke,

We thank Governor Blanco and her staff for the opportunity to have this type of input into the planning for the healthcare summit. Although we are grateful, many of the participants noted that this is not the first time they have come together to discuss such issues and offer similar solutions and ideas. This reflects the complex nature of the problems at hand.

Information was collected during the course of six focus group meetings held beginning on February 12 and ending February 17, 2004, with the sole agenda being to address the six questions posed by the healthcare pre-summit. The meetings were held at different times, on different days, and in two different locations (Thibodaux and Houma) in order to accommodate the largest numbers of interested persons as possible. A total of 86 people attended the focus group meetings and another nine persons unable to attend the pre-summit meetings supplied written responses to the questions. Major themes and comments from all sources have been compiled into this report.

Stakeholders from a variety of agencies and organizations in Region 3 were represented at the meetings. Examples of the organization represented include: Lafourche Association for Retarded Citizens, Region 3 Public Health Nurses, Audubon Guest House and Magnolia Management (area nursing homes), Terrebonne General Medical Center administration, Thibodaux Regional Medical Center administration, St. Anne Hospital administration, Office of Mental Health, Region 3 Medicaid, Office of Addictive Disorders, Bureau of Community Support and Services, Office for Citizens with Developmental Disabilities, Health Standards, Terrebonne Association for Retarded Citizens, Peltier-Lawless Developmental Center, Advocacy Center for Long Term Care, Governor's Office of Disability Affairs, LSU Hospitals/LSUHSC Healthcare Services Division, South Lafourche Nursing Center, elderly parent group of middle-aged developmentally disabled individuals, citizen with epilepsy, citizen with mental illness, State Developmental Centers, Pinecrest, Hammond Developmental Center, parents of children at home with developmental disabilities, Nicholls State University nursing faculty, Louisiana Association of Exercise Physiologists, Paramedics, YMCA, chiropractor, pharmaceutical industry research representative, respiratory therapist, dietetics, Children's Coalition from Bayou Region, Lafourche Public Schools Social Services, Bayou Land Families Helping Families, and N'R Peace (HIV services).
Please do not hesitate to contact me should you have any questions or require further information.

Respectfully submitted,

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What challenges do the following populations pose in Region 3?

The uninsured population has essentially the same demand for healthcare as the insured. People on Medicaid have a different set of demands because the focus is on children and families. Medicare has a different focus on the elderly. Allocating resources is the challenge, defining the services and what the demands are for each group. (Measurement by demand may not be the best method, analogous to unemployment statistics.)

1a. Challenges with the uninsured populations

- Children may be covered but mothers may not be
- Male population is largely without coverage
- With 850,000 uninsured people in Louisiana, it is estimated to cost 1.5 to 2.0 billion dollars to insure. Charity spends 500 million to take care of these folks.
- Dramatic effect on hospitals. If what happened at Earl K Long happens at Chabert, we will see some hospitals fold
- Children with psych problems who are uninsured and actively psychotic with auditory hallucinations, there is no help and no preventative measures
- Uninsured fail to get services until acutely ill then become hospitalized and more of a financial burden
- All preventative care has been done away with so burden now for all more acutely ill, which in turn contributes to homelessness, poverty, crime

1b. Challenges with the Medicaid population

- Reimbursement issues—the rate paid to providers is not comparative to representative rates (For example, Medicaid pays $3.68 per hour for a counselor for a child with emotional and/or mental problems. Louisiana is using 1995 schedule of reimbursements for compensation, which is cost-saving but not realistic), which contributes to the problem of
- Finding providers to take Medicaid patients
  And
- Finding providers to serve people with special needs (developmentally disabled).
- Community referrals (Family Practitioners, General Practitioners, Primary Care Providers) to specialists are problematic because some will “guard” their referrals because they are afraid of losing the business. Also, when referrals do occur, need better communication between PCP and specialist
- Large emphasis on LACHIP for kids but problems finding providers
- Even with Medicaid, HIV+ patients cannot get transportation to Chabert to keep appointment, get medications, and remain compliant
- Chiropractors are not reimbursable with Medicaid and chiropractors could be used as providers
- Treating a population that is the result of lifestyle of past 60-65 years. As we move forward this population will be healthier and desire better care for heart, etc. Are you going to take care of what presents today or what will present in the future? The problem is that politics doesn’t live in the future

- Many patients state that they are treated poorly in private physicians offices and would rather access Chabert, where they feel they are treated better

1c. Challenges with the Medicare population

- Medicare is federal, has supplements that pay what Medicare does not, and is probably the least of the challenges.
- Some research indicates that men are favored more in Medicare than women. Men tend to have acute episodes requiring healthcare and women need more long term care. Medicare more readily pays for acute care events than long term.

1d. Challenges with the privately insured

- Increased deductions. Deductions astronomically raised and people have trouble coming up with that (can be thousands of dollars per year).
- Increasing premiums with less and less coverage
- Increasing co-pays
- No pre-existing conditions if the employee changes policies
- COBRA can be expensive
- Waiting period between policy changes often has 2-3 week wait where individual is not covered
- Downsizing in businesses results in decreased coverage or eliminates coverage
- There is a bureaucratic maze when filing claims, and people often end up contesting their payments made by the insurance companies, and writing lengthy appeals. The general consensus is that this is in order to stall and delay legitimate payments.
- The employer strategy is to transfer as much of the cost as possible to employees in order to remain profitable. We have moved from a world where employers financed healthcare systems to where now the government is financing the healthcare system. Questions arise, such as, What is the philosophy of the dollar distribution? Issues of distributive justice and who needs it the most also arise.
- Penalties for going outside of the network for state employees
- Immunizations at private MDs costs couple of hundred of dollars, but only $10 or so through public health
- Charity hospital system is now taking insured patients, which threatens the other not-for-profit and profit-based hospitals.
- Specialty hospitals feed off of the high end insured populations, which carves into the business of the profit-based hospitals

What are the health care needs concerning the following in Region 3?

2a Health care needs of Children

- Not all are on LACHIP or Medicaid. Although efforts have resulted in significant enrollment, still need to perform outreach
- Dental nonexistent, difficult to access dental providers

- Nutrition is poor (with poor nutrition you see increased susceptibility to illness, infection, poor school performance, etc)
- Psychological services are limited—limited # of Medicaid providers and often at a great distance
- Obesity, lack of activity (combined with poor nutrition)—advertisements in schools and availability in schools of fast foods. Schools are looking for easy money as an easy way out of budget crunches
- Re school health—kids do not get instruction re Diabetes Mellitus, insulin, etc. Kids with ADHD on Ritalin, etc., without adequate monitoring or follow-up
- Louisiana with one of the highest infant mortality rates in the US and premature infant rates. Need aggressive prenatal care and counseling. For example, many pregnant women still do not know about taking folic acid.
- Pregnant women need substance abuse assistance and rehab services
- Preconception counseling
- Evaluation and treatment for ADD/ADHD
- Affordable options for hearing aids for those who do not qualify for Medicaid or Children's Special Health Services

2b. Health care needs for those ≥ 65 years old

- Polypharmacy with redundancy, some antagonistic to each other, no medication teaching, no inventory or monitoring of prescriptions
- Medications are expensive—elderly often must decide whether to buy meds or eat
- Supports and services to maintain in the home before slips/falls—need to enhance and expand, also have more activities with same age other elders
- Health needs for ≥65 are changing. What will the needs be? Long term care and alternate living arrangements (assisted living, etc)
- A 65 year old twenty years ago is a lot different than a 65 year old now. A real divergence related to proper nutrition, exercise, taking better care of self.
- 95% of patients in pulmonary rehab are ≥65 years old, and being in rehab has reduced hospitalization by 80%, so those programs are working and cost-effective
- Funding for nursing homes is deplorable-- $30 per day
- Older people raising their children's children face different problems than when they were raising their own children and need more supports
- Institutionalized care for the elderly was summed up by one nursing home owner as, "people would rather go to a funeral home than a nursing home"

2c. Health care needs for those having developmental disabilities

(Should probably differentiate disabled adults as a separate entity since there are assistive technologies that they can access in order to return to work, etc.)

- Finding provider able to provide health care (low reimbursement, specialized care, increased time, etc For example, an autistic child cannot be mainstreamed in a waiting room). Providers make decisions based on economics and will not see providers spending this inordinate amount of time with the developmentally

disabled. Efforts to educate medical providers re special needs can be successful (Most physicians think that having a handicap accessible bathroom suffices for all disability)

- Same issues as those identified for the elderly: lack of coordinated care, overmedicated, lack of any prevention programs, lack of any dental programs, poor in home supports. Mostly Medicaid, so share all of those problems as well.
- The push is to have institutionalized individuals out of the institution and into the community, but will still need those same services receiving in the institutions. It is imperative that those with developmental disabilities have a choice and decision about where they receive their care. Not all of the developmentally disabled can be placed at home or in group homes in the community, and need to remain institutionalized.
- Parents of middle-aged developmentally disabled individuals strongly felt that the current developmental center institutions providing care in Region 3 and elsewhere were doing a good job and should continue to be funded at least at current levels.

2d. Health care needs of those with mental illness

- Share many of the same issues with the elderly and developmentally disabled.
- Mental health clinics are bursting at the seams; services are limited to the most severely ill, few psychiatrists, and increasing numbers of those who need services. Admission criteria of clinics squeeze out those who need services but are not severely ill—typically only those with suicidal or homicidal ideation and those who are gravely disabled get services. It is possible to intervene prior to this severe point and prevent escalation of symptoms.
- Few providers related to poor reimbursement by Medicaid
- Need case management
- Need to differentiate mentally ill and mentally retarded—cannot treat mentally ill like mentally retarded (just give them halperidol!—mentally retarded cannot be productive on halperidol, etc.)
- Child and adolescent mental health lacking. Only see most critically ill, and mental health problems run rampant in children and adolescents.
- No resources for mental health with HIV—no counseling for depression, suicidality, other issues impinging on adherence, which may in turn affect transmission rates.
- No mentally ill inpatient beds for children or adolescents. Also, forensic adolescents cases are placed in with mentally ill adolescents.
- No counseling at mental health centers—medication only. Even then, it is hard to get appointments.
- Few crisis services. Must actively make a suicide attempt in order to receive any help.

2e. Health care needs for those with addictive disorders

- Again, same problems identified as mental illness and developmentally disabled

- No substance abuse beds
- Revolving door is the predominant treatment
- Need more supports in the community
- Continue with what we have, and avoid further cuts
- Comorbidity of addictive disorders with mental illness up to 50% and studies show that receiving both mental health and substance abuse treatment from the same team results in improvement, better recovery, better length of time in recovery
- With HIV+ persons, it is easier to refer to a substance abuse clinic than to a mental health clinic, but HJIV+ patients needs largely remain unmet as well

3. Strengths of Region 3 health care

- Thibodaux area MD believes that the area physicians are sensitive to the needs of their patients
- Health access program such as Robert Wood Johnson and the St Mary Chamber of Commerce created the Chamber of Health. Did a needs survey, created transportation for the indigent, medications for indigent, also have clerkships for Tulane and LSU medical students
- Giving people options and choices for how they want services delivered—for example, institutionalized or at home/community—for elderly, disabled, etc.
- Availability of technology in this area (cancer, cardiovascular) and high technology attracts competent healthcare providers and specialists
- Active public health system identifies at-risk, educating and getting kids covered in LACHIP
- Community groups that could be used to deliver care
- Nicholls State University, and the nursing program at Nicholls State University
- Strong public health infrastructure despite cutbacks in the last 8 years
- Caring health care professionals, caring and dedicated state agency employees, caring advocacy groups—a caring human resource to address some of these problems.
- Chabert does a really good job.
- Every parish still has a community hospital.
- Children's Special Health services—availability to treat some children with special health needs; however, many still do not qualify for LaChip or CSHS.
- Early Childhood Supports and Services (Terrebonne parish only) treating whole family of at risk children aged 0 to 5 providing infant mental health.

4. Identification of gaps and how to address some of these in Region 3

- Need dental care—other than full mouth extraction, no dental care, no periodontal care, no preventative care, no restorative care. Louisiana ranks 49th in the # visits the average population makes to dentist. More people in this state with full sets of dentures than any other state. Dentures become loose and ill fitting 7-10 years after fitting, resulting in poor nutrition, decreased overall health, anemia, infections, poor operative risks, increased length of stays, increased morbidity.

- Lack of dental care cuts across all age groups.
- Can pay $86 for an ophthalmology visit but no funds available for glasses
- Limit to the number of meals on wheels can receive
- The paraprofessional workforce (CNAs, HHAs, techs, sitters)—vocational schools are not filling the needs, takes 14 weeks and people cannot go without a paycheck for that long. Field is not attractive due to low pay, no benefits, nights and weekend work
- The working poor—this group needs to be defined and address their healthcare needs
- Lack of preventative care results in increased medical care
- Case managers/Social Workers—no therapeutic services, just management.
- Re: Occupational Therapy/Physical Therapy for elderly and disabled, must show marked improvement in order to continue to receive services and sometimes just the prevention of further decline may well represent "improvement". Need to have "Maintain status quo" as a goal
- What to do when Charity and Chabert ED on diversion?
- As Charity system reduces services, area hospitals are having to pickup and this causes economic hardships. For example, impending closure of psychiatric units will result in extraordinary strain on existing psychiatric units
- Hospitals are having to pay premium dollars for medical and nursing staff, which results in the closure or elimination of other services and units.
- Shutting down HIV clinics, addiction clinics, and other outpatient clinics results in people accessing ED for care, contributing to all of the problems with increased hospitalization burden, misuse and overburdening of the EDs.
- Lack of mental health services. Need more crisis intervention services, partial hospitalization programs and day treatment programs as effective, and cost-effective measures.
- Region 3 has no level one trauma service; There is only one neurosurgeon in Region 3. Head injury causes tremendous morbidity and mortality in this region and this one neurosurgeon has no one to share on-call with. Again, this goes back to reimbursement—brought in by ambulance, no insurance, no reimbursement for staffing for trauma care, etc.
- Cannot continue to care for high risk and at-risk populations without adequate reimbursement.
- Charity system is not the source of the current healthcare woes. If the Charity system collapses, everyone else would be inundated.
- We have state of the art treatment for addictive disorders, yet not enough of these services to treat the daily waiting list of over 1000 persons.

5. What changes can be made, with consideration to access, quality, and cost? What are potential funding sources? What changes can be made without additional funding?

- **One-stop, single point of entry for all referrals and services**.

A warm line, referral line could be run by community group or university

Communicate to consumers all of the available services they can access
Assess for services and start the referral process.
Look at other states with model programs (Oregon, Washington, North Carolina, Colorado)

- **Examine best practices in other states and redesign our system to be more cost-effective**. Basic insurance program, modeled on other successful states (Oregon, Washington)

- Transportation resources for people in rural areas to reach physicians and care before needing hospitalization --could follow the Council on Aging Program model

  After-school programs could be more successful if transportation were available to get kids to the library, etc. (transportation currently not available due to liability issues)

- Increase taxes. Most individuals in these pre-summit meetings were ready to pay additional taxes ***if*** they felt that the funds were going to be used efficiently.

- **Primary care provider perspective:**
  View Medicaid as marketing. Not every member of the family on Medicaid and can be used to increase the patient base
  Medical community needs to address polypharmacy of the elderly
  Medical community needs to change paradigm of allopathic medicine to incorporate more prevention
  Consider state-wide initiative to educate healthcare providers about the needs of the developmentally disabled
  Eliminate "doctor hopping" and that physicians do not know what other physicians treating the same patient are doing. This is difficult in the era of HIPPA.

- Follow Bush's lead and **increase faith-based initiatives**. These alternative funded agencies (churches, community organizations) could offer mental health, substance abuse, elder services, etc.

- Curtail advertisements that say "Come to my emergency room" and mislead the public in believing that they are the ones to define a true emergency. This leads to the misuse of EDs.

- Healthcare is an industry—grow the industry like you would any other business.

- Look at where wasting money in order to decrease fragmentation, increase consolidation; look at total programming in order to be useful to end-user.

  Reduce paperwork. Multiple regulations generate multiple forms, some replicate and are redundant. Review and streamline, thus reducing administrative overhead.

Same with services. **Eliminate duplication of services** and streamline the communication between all services to eliminate the "right hand doesn't know what the left hand is doing" phenomena. Revamp existing services to consolidate and decrease costs (resistance to this because of turf issues, bureaucracy, layers within departments.) Teach state agencies to work together instead of continue to offer fragmented, fractured and redundant services. Need intra-state agency partnerships and communication re what everyone is doing. Eliminating multiple tiers of regional offices, redundancy, and streamlining could reduce administrative overhead. (For example, could combine the Department of Social Services with DHH since they do so many of the same services.)

Excessive monitors and regulatory agencies. Recognize that all agencies need watchdogs, but one woman reported she had 17 to 22 different agencies that monitor her services. All were looking at essentially the same items, yet they would have different and often contradictory recommendations. Eliminating redundancy and streamlining the review process could reduce administrative overhead.

- Integrate services between addictive disorders and mental illness as an evidence-based practice initiative to improve outcomes

- **Grant writing**.
  State of Louisiana should form partnerships with community organizations and funding agencies, similar to the Chamber of Health in St Mary's.
  Form collaborations and establish grant-writing programs.
  Seek community health center grants and partner with Nicholls State University Department of Nursing.

- **Fund aggressive prevention programs.**

  Spend money on preventative care. (For example, spend money to catch those overweight youths to decrease chances of developing Diabetes Mellitus, increase exercise, increase nutrition knowledge, etc.) Yet reluctant to do so because there is so little data on long term outcomes. Why not develop a research plan with a control group and do the long term studies? Will need to transcend the politics and administrative change-overs every 4 or 8 years, for the duration of the study. Watch healthcare patterns, Goal would be empirical evidence to spend $ now will save $ in the future. Let the new LSUHSC Public Health Program organize this effort.

  Need incentives for people who access wellness and preventative programs and services (exercise, healthy nutrition, smoking cessation) by offering benefits to health clubs and insured. This is like the good driver rebate on car insurance. Need to include those who are not insured or have government insurance as well.

Put physical education classes back in school and focus on nutrition.

- Pick what institution(s) should deliver healthcare (schools, churches, hospitals). This should be a community decision.

- Access to care issues with different ethnic groups who do not speak English—need some type of outreach program

- Establish healthcare IRAs so that people can put money aside when they are younger to use only for long term care.

- The dollars for healthcare programs and services should follow the patient, not the institutions and agencies.

- Address the shortage of healthcare providers, especially nurses and nursing faculty.

- In order for healthcare to be funded, higher education will take the hit. This type of system needs to stop.

- **Maintain public health initiative** such as immunizations. Influx of federal dollars for bioterrorism does not meet the public health needs or overall mission. Only 0.9% of healthcare dollars spent on public health.

  Follow a public health service model, similar to a pyramid. Fund the bottom level first—population based services, then preventative health services, then primary, secondary and tertiary services. Currently, this is inverted.

- Increase end of life care and palliative care benefits as a cost savings measure (will reduce hospitalization costs).

- When designing a program, design from the perspective of providers of patients? Who generates the description of the need? Re-orient to the need factor and look for value in these programs.

- The DHH Bureau of Community Supports and Services that administers the New Opportunity Waiver has operated with little oversight and has tended to micro-manage providers. Layer after layer of monitoring has been added, with decision making and flexibility taken away from families, and policies reflect a lack of faith in providers. An immediate legislative and provider oversight solution is sought.

- The current Medicaid Waiver program has a long waiting list. Perhaps the implementation of a Provider Fee similar to the one that funds ICF/MR would alleviate some of this problem.

- Hold providers accountable for the services they were hired to provide

- Use gaming and tobacco taxes to insure the working poor

- Regular public hearings and forums to determine local needs and decision-making.

- The Rural Hospital Preservation Act, was underfunded in 2002-2003, and as a result, the rural hospitals are not getting the funds that they need.

- Amendment 3 is an important piece of legislation affecting healthcare that needs to be activated.

- Need permanent, long term strategies for healthcare that are not dependent upon who is in office and do not change with each administration.

6. How to prioritize spending?

- **Revamp Medicaid reimbursement schedules**. More than any other factor, this was linked with provider issues, and issues with all concerned populations in receiving adequate health care.

- **"Children are the future."** Invest in prenatal programs and decrease the infant mortality rates in Louisiana.

- **Prevention.** Do the study, focus on wellness. Prevention efforts for HIV, mental illness, substance abuse/addictive disorders.

- **Mental health care** for all segments of the population.

- **Dental care** for all age groups**.**

- **Long term care**, assisted living, for elderly**.**